# 1010 MEDICAL MANAGEMENT (MM) ADMINISTRATIVE REQUIREMENTS

REVISION DATES: 10/01/15, 02/01/15, 12/18/14, 07/01/12, 04/01/12, 01/01/11, 10/01/10, 10/01/08, 11/01/05

INITIAL EFFECTIVE DATE: 10/01/1994

## A. MM PLAN

Contractors must develop a written MM Plan that describes the Contractors' methodology to meet or exceed the standards and requirements of contract and this Chapter. Contractors must submit the MM Plan, and any subsequent modifications, to AHCCCS Medical Management (MM) for review and approval prior to implementation. Please refer to Appendix C for the MM Plan Checklist and to Appendix G for the MM Work Plan Guide and Template. At a minimum, the MM Plan must describe, in detail, the Contractors' MM program and how program activities will assure appropriate management of medical care service delivery for enrolled members. MM Plan components must include:

1. A description of the Contractors' administrative structure for oversight of its MM program as required by Policy 1010, Section C of this Chapter, including the role and responsibilities of:
    a. The governing or policy-making body
    b. The MM committee
    c. The Contractor Executive Management,
    d. MM program staff
2. An organizational chart that delineates the reporting channels for MM activities and the relationship to the Contractor Medical Director and Executive Management.
3. Documentation that the governing or policy-making body has reviewed and approved the Plan.
4. Documentation that appropriately qualified, trained and experienced personnel are employed to effectively carry out MM program functions and meet Contractor qualifications required by Policy 1010, Section C.

5. The Contractor's specific MM goals and measurable objectives as required by Policy 1020 of this Chapter.

6. Documentation of how each of the following processes are implemented and monitored to ensure quality and cost-effective care is provided to enrollees in compliance with State and Federal regulations:

    a. MM Utilization Data Analysis and Data Management

    b. Concurrent Review

    c. Discharge Planning

    d. Prior Authorization (PA)

    e. Inter-Rater Reliability

    f. Retrospective Review

    g. Clinical Practice Guidelines

    h. New Medical Technologies and New Uses of Existing Technologies

    i. Case Management/Care Coordination

    j. Disease/Chronic Care Management

    k. Drug Utilization Review

7. The Contractor's method(s) for monitoring and evaluating their service delivery system and provider network that demonstrates compliance with Policy 1020.

8. A description of how delegated activities are integrated into the overall MM program and the methodologies for oversight and accountability of all delegated functions, as required by Policy 1010 C.

9. Documentation of input into the medical coverage policies from contracted or affiliated providers and members.

10. A summary of the changes made to the Contractor's list of services requiring prior authorization and the rationale for those changes.

## B. MM WORK PLAN

The Contractor is responsible for developing a work plan that identifies the Contractor's goals; methodology for improvement; and monitoring efforts related to the MM program requirements outlined in Policy 1020. Refer to Appendix G for the MM Work Plan Guide and Template.

The Contractor's work plan shall:

1. Be submitted in an acceptable format or in the template provided by the MM Unit,
2. Support the Contractor's MM Plan goals and objectives,
3. Include goals that are quantifiable and reasonably attainable,
4. Include specific actions for improvement, and
5. Incorporate a plan, do, study, act (PDSA) methodology for testing an action designed to result in a desired improvement in a specific area. Refer to AMPM Policy 970 for details related to PDSA methodologies.

## C. MM EVALUATION

An annual narrative evaluation of the effectiveness of the previous year's MM strategies and activities must be submitted to MM after being reviewed and approved by the Contractor's governing or policy-making body. The narrative summary of the previous year's work plan must include but is not limited to:

1. A summary of the MM activities performed throughout the year with:
    a. The title/name of each activity
    b. The desired goal and/or objective(s) related to each activity
    c. The Contractor staff positions involved in the activities
    d. Trends identified and the resulting actions implemented for improvement
    e. The rationale for actions taken or changes made
    f. A statement describing whether or not the goals/objectives were met

2. Review, evaluation and approval by the MM Committee of any changes to the MM Plan, and

3. Necessary follow-up with targeted timelines for revisions made to the MM Plan.

The MM Plan and MM Evaluation may be combined or written separately, as long as required components are addressed and are easily located within the document(s) submitted. Refer to Appendix C, *MM Plan Checklist*.

Refer to Policy 1030 of this Chapter for reporting requirements and timelines.

## D. MM ADMINISTRATIVE OVERSIGHT

1. The Contractor's MM program must be administered through a clear and appropriate administrative structure. The governing or policy-making body must oversee and be accountable for the MM program. Contractors must ensure ongoing communication and collaboration between the MM program and the other functional areas of the organization (e.g., quality management, member and provider services and grievances).

2. The Contractors must have an identifiable and structured MM Committee that is responsible for MM functions and responsibilities, or if combined with the Quality Management Committee, the agenda items and minutes must reflect that MM issues and topics are presented, discussed and acted upon.

    a. At a minimum, the membership must include:

        i. The Medical Director or appointed designee as the chairperson of the committee
        ii. The MM Manager
        iii. Representation from the functional areas within the organization, and
        iv. Representation of contracted or affiliated providers.

    b. The Medical Director, as chairperson for the MM Committee, or his/her designee, is responsible for the implementation of the MM Plan, and must have substantial involvement in the assessment and improvement of MM activities.

    c. The MM Committee must ensure that each of its members is aware of the requirements related to confidentiality and conflicts of interest (e.g., a signed statement on file or MM Committee sign-in sheets with requirements noted).

d. The frequency of Committee meetings must be sufficient to demonstrate that the MM Committee monitors all findings and required actions. At a minimum, the Committee must meet on a quarterly basis.

e. Committee meeting minutes must include the data that are reported to the Committee as well as, analysis and recommendations made by the Committee. Data, including utilization data, may be attached to the Committee meeting minutes as separate documents as long as the documents are noted in the Committee meeting minutes. Recommendations made by the Committee must be discussed at subsequent Committee Meetings. The MM Committee must review the MM program objectives and policies annually and update them as necessary to ensure:

   i. The MM responsibilities are clearly documented for each MM function/activity,
   ii. The Contractor staff and providers are informed of the most current MM requirements, policies and procedures in a timely fashion in order to allow for implementation that does not adversely impact the members or provider community,
   iii. The providers are informed of information related to their performance (i.e., provider profiling data), and
   iv. The MM policies and procedures, and any subsequent modifications to them, are available upon request by the AHCCCS MM Unit.

3. The MM Program must be staffed with a sufficient number of appropriately qualified personnel to carry out the functions and responsibilities specified in this Chapter.

   a. Staff qualifications for education, experience and training must be developed for each MM position.

   b. The grievance process must be part of the new hire and annual staff training including, but not limited to:

      i. What constitutes a grievance,
      ii. How to report a grievance, and
      iii. The role of the Contractor's quality management staff in grievance resolution.

   c. A current organizational chart must be maintained to show reporting channels and responsibilities for the MM program.

4. The Contractors must maintain records that document MM activities, and make the information available to AHCCCS MM Unit upon request. The required documentation must include, but is not limited to:

    a. Policies and procedures,

    b. Reports,

    c. Practice guidelines,

    d. Standards for authorization decisions,

    e. Documentation resulting from clinical reviews (e.g. notes related to concurrent review, retrospective review, and prior authorization),

    f. Meeting minutes including analyses, conclusions, and actions required with completion dates,

    g. Corrective Action Plans (CAPs**)** resulting from the evaluation of any component of the MM program such as inter-rater-reliability, and

    h. Other information and data deemed appropriate to support changes made to the scope of the MM Plan.

5. The Contractors must have written policies and procedures pertaining to:

    a. Information/data received from providers is accurate, timely, and complete.

    b. Reported data is reviewed for accuracy, completeness, logic and consistency, and that the review and evaluation processes used are clearly documented.

    c. All member and provider information protected by Federal and State law is kept confidential.

    d. The Contractor shall inform providers and appropriate staff of the following:

        i. MM requirements and updates,
        ii. Utilization data reports, and
        iii. Profiling results.

    e. Identification of provider trends and subsequent necessary corrective action regarding over/under utilization of services.

f. Quarterly evaluations and trending of Contractor internal appeal overturn rates.

g. Quarterly evaluations of the timeliness of service request decisions.

h. Annual review of prior authorization requirements that encompasses the analysis of prior authorization decision outcomes, including but not limited to, the rationale for requiring prior authorization for types of services such as high dollar, high risk, or case finding for care management.

6. Contractors must have in place processes which ensure:

a. Under 42 C.F.R. 438.210(b)(3), qualified health care professionals, with appropriate clinical expertise in treating the enrollee's condition or disease, will render decisions to:

i. Deny an authorization request based on medical necessity,
ii. Authorize a request in an amount, duration, or scope that is less than requested, or
iii. Make a decision involving excluded or limited services under Arizona Revised Statute A.R.S. 36-2907(B) and AHCCCS Administrative Code R9-22-201 et seq (Article 2), as specified in section 6.d.(1) of this policy.

b. Under 42 C.F.R. 438.406(a)(3), qualified health care professionals, with appropriate clinical expertise in treating the enrollee's condition or disease, and who have not been involved in any previous level of decision making, will render decisions regarding:

i. Appeals involving denials based on medical necessity,
ii. Grievances regarding denial of expedited resolution of an appeal, or
iii. Grievances and appeals involving clinical issues.

c. There is prompt notification to the requesting provider and the member or member's authorized representative or Medical Power of Attorney, as applicable, of any decision to deny, limit, or discontinue authorization of services. The notice must include information as specified in the AHCCCS Contractor Operations Manual (ACOM), Policy 414 and Arizona Administrative Code 9 A.A.C. 34.

d. For purposes of Section 1010 (C) (6):

i. The following qualified health care professionals have the appropriate clinical expertise to render decisions based on previously established contractor standards and clinical criteria for skilled and nonskilled services within their scope of practice: physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor. Decision making includes determinations involving excluded or limited services under A.R.S. 36-2907 and AHCCCS Administrative Code R9-22-201 et seq (Article 2).

ii. In addition to those providers listed in 1010 (C) (6) (d) (1), the following health care professionals have the appropriate clinical expertise to render decisions for non-skilled Home and Community Based Service (HCBS) such as attendant care, personal care, homemaker, habilitation, and non-nursing respite care:

(a) Arizona Long Term Care System (ALTCS) case management staff when the individual is a:

(i) Registered Nurse,
(ii) Licensed Practical Nurse,
(iii) Degreed social worker, or
(iv) An individual with a bachelors or masters degree in a related field.

(b) ALTCS case management staff with a minimum of two consecutive years of experience in long term care when the individual does not have a degree or a license.

e. Ensure consistent application of contractor standards and clinical criteria and ensure consistent decisions that include inter-rater reliability criteria and monitoring of all staff involved in this process. A plan of action must be developed and implemented for staff who fail to meet the inter-rater reliability standards.

7. All Contractors must maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement its MM Program. Data elements must include but are not limited to:

    a. Member demographics,

    b. Provider characteristics,

    c. Services provided to members, and

    d. Other information necessary to guide the selection of, and meet the data collection requirements for, improvement activities.

8. Contractors must oversee and maintain accountability for all functions or responsibilities described in this Chapter that are delegated to other entities. Documentation must be kept on file, for AHCCCS review, and the documentation must demonstrate and confirm that the following requirements have been met for all delegated functions:

    a. A written agreement must be executed that specifies the delegated activities and reporting responsibilities of the entity to the Contractor and must also include provisions for revocation of the delegation or imposition of sanctions for inadequate performance.

    b. Contractors must evaluate the entity's ability to perform the delegated activities prior to executing a written agreement for delegation. The delegated agreement must be submitted with the contractor review checklist (refer to the AHCCCS Contractor Operations Manual).

    c. The performance of the entity and the quality of services provided are monitored on an ongoing basis and formally reviewed by the Contractors annually, at a minimum.

    d. The following documentation must be submitted to AHCCCS:

        i. Annual evaluation reports to be included in the MM Plan, and

        ii. Notification of the issuance of corrective action plans, documentation related to sanctions, notices of non-performance, and deficiencies and notices to cure within 30 days of issuance. The actual documents must be kept on file and available for AHCCCS review.

9. Contractors must ensure that:

    a. Compensation to persons or organizations conducting prior or prospective authorization, and concurrent or retrospective review activities are not structured so as to provide inappropriate incentives for selection, denial, limitation or discontinuation or authorization of services, and

    b. Providers are not prohibited from advocating on behalf of members within the service provision process.